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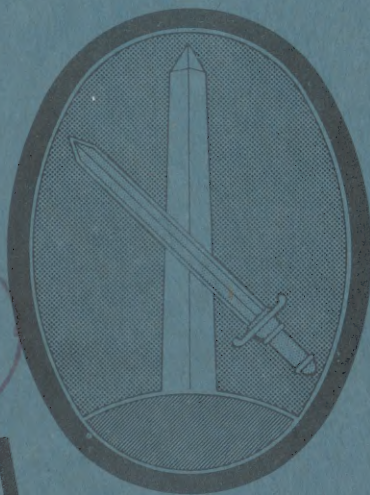
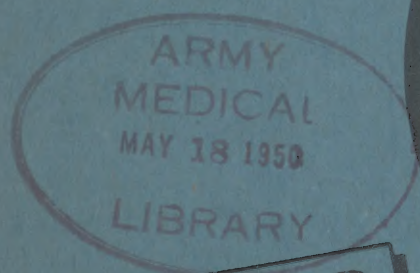
RESTRICTED

# MONTHLY

# HEALTH

# REPORT

Military District of Washington



RESTRICTED

April 1950





# MONTHLY REPORT

## M D W

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## HEALTH



HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON  
Room 1543, Building T-7, Gravelly Point  
Washington 25, D. C.








## INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as the basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Medical Department personnel in the field.



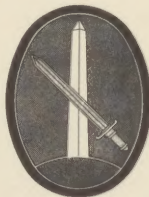
*Robert E. Bitner*

ROBERT E. BITNER  
Colonel, MC  
Surgeon



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## PROFESSIONAL SERVICES

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### DOCTOR-PATIENT RELATIONSHIP

by

Colonel Robert E. Bitner, M.C.

Surgeon, Military District of Washington

"Doctor-Patient Relationship" deals with individuals. Were we in the business of selling merchandise we would use the term "Salesmanship". However, there is a difference in the business of selling professional medical service. Salesmanship implies a one-sided transaction, whereas the relationship between a doctor and a patient is a mutual one. The patient is seeking the aid of a professional individual. The term "individual" is used meaningfully, for the doctor is an individual, and acts individually, even though there may be group association. We have no doubt about the individuality of the patient.

What does a patient expect of the doctor? What must the doctor do and what must he not do to create a feeling of confidence toward him by his patient? What does the doctor expect of his patient in this mutual relationship? These are questions that it is hoped may be answered in part, at least, by this article.

First, let us analyze the doctor's status. The patient presents himself to the doctor either willingly or unwillingly. Whether the doctor is garbed in OD or "civies" should have no bearing on this relationship. The patient expects certain consideration from him. The initial contact may determine future relationship between doctor and patient. The doctor, either by his appearance or apparent attitude, may without speaking a word, turn the patient against him at the time.

I should like to refer to the doctor's appearance. He may be unkempt -- not shaved, or have long uncombed hair, dirty finger nails, and soiled clothing. Yes, that does occur occasionally; even in the Army, though we hesitate to admit it; and the patient may take a glance also at those neglected shoes. You say that only the fastidious patient notices those things. True, I will admit but we must, as doctors, deal with him also, and we don't know when he will be calling upon us.

The odor of alcohol on a doctor is repulsive to even the alcoholic. He may have come for help in the very matter of his alcoholism. He has little or no confidence in such an individual. If drink we must, it is best not to carry it to the nose of the patient. Tobacco, likewise, is repulsive to some patients. However, to the majority it is accepted in these days of the cigarette. But there is one act concerning tobacco that the patients do not appreciate. I cite it because it has occurred and was a cause of complaint. That act is the smoking of a cigarette, a cigar, or even worse, a pipe while in the process of the actual examination. It seems that the patient will accept the smoking habit up to a certain point and then calls a halt.

So much for the surroundings. Now let us consider attitude. Any semblance of disinterestedness immediately creates a feeling of opposition, even to antagonism in the patient. The initiation of the conversation by such a question as "What is the matter with you?", and particularly, if spoken gruffly may get a rather sharp reply "That's what I came to you for." Opening a conversation with "What is your complaint?", or "How are you ailing?" creates a more favorably relationship and gives the patient a feeling of interest. An interested attitude gains the confidence of the patient and sets him at ease for the remainder of the visit.

The patient has a definite problem, otherwise he would not be coming to the doctor. This problem does not always resolve itself into organic pathology. Many of the patients have functional disorders as we well know. The stress and strain of modern life in our daily tasks; economic problems; domestic problems; poor employer-employee relationships do create many functional disorders which the doctor must consider. They are present in civilian patients as well as Army patients. The cause of the functional disorder must be ferreted out. Here we get into the field of psychosomatic medicine of which we hear so much today. This field has been existent for the span of humanity, but was little cultivated during the heyday of Pathology. Now we find everything in medicine cannot be explained at the autopsy table, or in the laboratory, so we are working again in the same field but call it "Psychosomatic Medicine".

An attitude of superiority on the part of a doctor creates either antagonism or a feeling of inferiority in the patient. Confidence can be gained by letting the patient feel that he can "open his heart" to the doctor. Few patients will "open their hearts" to a doctor who is aloof to them.



## PROFESSIONAL SERVICES

It has been said that a good history is 50% of diagnosing a patient's problem. Certainly it is highly important. Now, one of our great problems, particularly in the service where we have such a volume of patients, is to get at the bottom of the patient's problem as soon as possible. We can ill-afford to spend hours getting a history, yet that history is all-important. It has been said, "If patients were allowed to talk more and were examined less, it would be a good thing for medicine in general". That writer, I am sure, was trying to bring out the point that we must allow the patient to tell his story. Interruptions by the doctor, his bombardment of questions, may fail to bring out the very points that the doctor desires to know. Let the patient tell his story; interrupt him only if he becomes too loquacious or is inclined to circumlocution.

Failure of a doctor to follow through a case brings complaints of lack of attention. The doctor may have completed his examination, arrived at a diagnosis of "No disease found" or "emotional instability" or may even have found some organic pathology, but failed to get the information across to the patient. Each case should be definitely disposed of; letting the matter "hang in air" will be sure to be subjected sooner or later to the winds of complaint.

Let us look at the patient now. These days we are seeing many patients of all ages and both sexes with all the complaints that any civilian practitioner would see; and as we move about the Army our field of medicine is broadened. Our campaigns to control cancer, heart disease, rheumatic fever, poliomyelitis and even the common cold bring us many patients who admittedly or not, are worried many times about one of these diseases. We must realize that women particularly are cancer conscious. They may be seeking an examination to confirm or disprove their suspicions which incidentally, and too often, are aroused at the bridge table rather than the examining table. A pointed question or at least a positive statement by the doctor will in a great number of cases relieve this unstated anxiety.

Men fear heart disease and arteriosclerosis, and after fifty, prostatic hypertrophy and cancer. Examination and a positive statement with treatment is indicated; or a positive statement that the individual has no indications of these mentioned diseases will tend to alleviate the individual's concern.

It is realized that much has been written about doctor-patient relationship and that each individual will have his own views on the subject. These are simply my views presented for your consideration.

\* \* \* \* \*

### REPORT OF A CASE OF ERYTHEMA MULTIFORME EXUDATIVUM, BULLOUS TYPE

By N.P. Danoff, MD

Station Hospital, Fort Belvoir, Virginia

A 22 year old white male was admitted to Fort Belvoir Station Hospital on December 27, 1949. His illness had begun 3 days previously with fever, anorexia and lesions on dorsum of left hand. At the same time he noticed a small vesicle on the glans penis.

The patient's history was non-contributory except for the fact that in 1948 he had an infection on the dorsum of his left hand following a blow. The initial lesion of his present illness started at the same site.

Physical Examination revealed a well-developed, well-nourished white male, 22 years of age who appeared toxic. There were multiform, erythematous, circumscribed lesions on the dorsum and palms of the hands and forearms with other isolated lesions of the same sort on the torso and lower extremities. The lesions appeared vesicular umbilicated and bullous. They yielded a clear fluid free of organisms on direct stain. There were lesions on the lip, labial and buccal mucosa and the tongue. There was no involvement of the eyes. (This may differentiate it from the Stevens-Johnson type.) The mucosa of the pharynx was reddened and covered with a moist greyish film. The glans penis showed a superficial ulceration. The skin between the lesions appeared normal. The temperature was 100°.



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## PROFESSIONAL SERVICES

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**Laboratory Findings:** On admission to Fort Belvoir Station Hospital, the CBC showed: RBC-5,250,000, Hgb-15 gms. WBC-12,150 with 65% neutrophils, 22% lymphocytes, 12% monocytes, 1% eosinophils. His urine was normal. Several Darkfield examinations were negative. Serological tests for syphilis were normal as was the x-ray of the chest. Blood serum proteins were determined and found to be: Total - 6.6 grams/100 cc; albumin - 3.1 gms/100 cc; globulin 3.5 gms/100 cc.

His treatment at this hospital was supportive which included daily doses of penicillin, high vitamin diet, nicotinic acid amide, and antihistaminic drugs. His condition did not respond well, and since the diagnosis was determined he was transferred to Walter Reed General Hospital on 1 January 1950.

The diagnosis was confirmed and the patient was started on aureomycin, per os, 250 mgm q.i.d., plus aureomycin mouth washes and soaks. He responded well to the above treatment and by 10 January was able to eat the general diet. Most of his lesions had by now desquamated. Aureomycin was discontinued on the 15th of January after 15 days of this medication. On discharge he was cured.

Erythema Multiforme Bullosum is an acute inflammatory disease characterized, as the name implies, with varied aspects of its lesions - macular, papular, bullous, and hemorrhagic; no two (2) cases being alike. As a rule, it is symmetrically bilateral with a predilection for the face, neck, arms, legs and dorsal surfaces of the hands and feet. Mucous membranes may be also involved.

**Clinical Signs:** The striking feature of this disease is the symmetrical distribution of bluish-red macules, papules, and bullae. The latter do not appear to arise from the normal skin. On the contrary they are surrounded by a red halo or develop from the edge of an erythematous patch. The bullae are tense and contain serous or hemorrhagic fluid. The fading lesions may leave a zone of temporary pigmentation. The ant. and post. trunk, and extensor surfaces of the extremities are frequently affected. Lesions may also occur on the lips, in the mouth, or on the conjunctiva.

**Constitutional Symptoms** - are often absent, but when the disease is extensive, fever, headache and arthritic pains may be present.

**Etiology** - The etiology of erythema multiforme is unknown. Some attribute it to foci of infection in the teeth, tonsils, sinuses, or uterus; others think it may be due to sensitivity to drugs - sulfonamides, or the absorption of toxic products from ingested foods. Most of the cases do occur in the spring or fall.

**Pathology** - consists of edema of the corium, dilatation of blood vessels and a perivascular infiltration consisting of lymphocytes, leucocytes, and red blood cells.

**Treatment** - is mainly supportive with antibiotics to prevent secondary infection. It is possible to deduce from the excellent result obtained with aureomycin in the case recorded above, that erythema multiforme may be infectious. Also that the etiological agent may be a virus hitherto undetermined.

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## PREVENTIVE MEDICINE

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### PERSONAL ADJUSTMENT AND MENTAL HYGIENE

#### The Disciplinary Problem

A soldier may be expressing his unhappiness or resentment over his place in the Army by disobeying orders. He may offer excuses when faced with assignments or with punishment. He may talk back, insult his superiors, or act in other insubordinate ways. He may interfere with other soldiers in the discharge of their duties. He may steal or damage property. Such cases may be minor or more serious, but it is clear that no matter what their degree, they have a bad effect on a company.



## PREVENTIVE MEDICINE

In the average case, the usual Army remedy under the Articles of War may have the desired effect. In some cases where there are further complications, punishment may serve only to aggravate the problem. What the officer has to ask himself in every instance is this: "Does this soldier do wrong because he does not know any better or has to learn the hard way, or are there more disturbing personal reasons for his acting in such a manner? Is this soldier so emotionally unstable or upset that he is not able to control his worries or fears of what will happen to him in the Army, or to his family because he is in the Army? Is he stepping out of line only since he has come into the Army, or was he out of step in civilian life as well?"

Remembering that a person's actions are usually due to his background, an officer should examine the records that are easily accessible to him. The soldier's service record may show that he is a chronic troublemaker. A review of his civilian background may reveal a basis for his behavior. Some inquiry should be made as to the kind of person he is, before it is decided what steps should be taken to make a better soldier of him.

If an officer understands what goes on in the mind of an otherwise normal soldier, who flies off the handle with an excuse of patriotic zeal, he may turn the man's energy into constructive channels. This soldier may become an asset instead of a liability to the company. It is such understanding that the psychiatrist can give the company commander in helping him to differentiate between the man who will continue to cause trouble and one who can become a positive element in the company.

### The Aggressive Soldier

The soldier who most loudly states his hatred for the enemy and his desire to go overseas, is not always the most reliable and may not always make the best fighter. The soldier who must tell everyone about his eagerness for action may be giving a pep talk to bolster his own courage. He may be expressing a picture of himself as he would like to be, while covering up his fear. Everyone is familiar with the blustering bully who is found weak when the chips are down. These men are usually not to be relied upon for more complicated or more important jobs in action. They rarely have the balance or the stamina to think clearly under pressure. They usually need a strong, guiding arm to help them along; and they need special approval, commendation, and reassurance to keep them going. These aggressive soldiers need many specific assignments to keep them occupied, and active physical work so they can burn up the energy they have to expend. They have a useful place in a fighting unit if they are given jobs that call for a great deal of activity without much responsibility. This kind of person may develop a loyalty to a strong officer who is willing to nurse him along; but if he continues to get into jams, psychiatric consultation should be called upon for an opinion.

Resentment and hostility are present in every soldier, particularly when he is under stress. If they are directed toward the enemy in the form of effective action, he is functioning as a good soldier and is less likely to develop more anxiety. If they are misdirected or cannot be expressed, excessively anxiety develops and may be disabling. Good morale protects the soldier from anxiety--first, by offering him the protection derived from group identification, and second, by directing hostility into proper channels. It does not produce hostility; it merely directs that which is already present.

### The Withdrawn Soldier

The soldier who never "gets in the way" may also turn out to be the one who lags behind at the crucial moment. If a soldier stays by himself most of the time and just barely fulfills his job responsibilities, he may go unnoticed for a long time before he is spotted. The company commander is very likely to miss him if there are many more active problems in the company. Yet this man may actually be very unhappy and worried about some personal problem for which he might receive help. He may be a shy fellow who can be encouraged to make real friends in the company and, in this way, put forth more drive and energy in his work. He may be so distressed or so anxious about his job or about combat duty that he is likely to break down completely at a later, more crucial stage. The company commander can save a casualty, physical and mental, if he discovers those unsociable soldiers who may need personal guidance or special programs, or even discharge under pertinent regulations.



# PREVENTIVE MEDICINE

## The Malingerer

The chronic sick caller is very often misjudged as a malingerer. Malingering is rare in medical practice, perhaps because few persons have sufficient knowledge to feign symptoms, but also because the malingerer is defined as one who, with malice aforethought, deliberately tries to give the impression that he is sick in order to deceive or conspire, or to avoid an unpleasant situation or an obligation. When so used repeatedly, this behavior may indicate a lack of responsibility or of moral sense. In the Army, rarely does a soldier deliberately resort to this device, nor does he successfully continue this practice over a period of time.

If malingering is suspected, a medical examination should be requested immediately. The medical officers, however, can only make a statement as to the soldier's physical condition. Since malingering involves fraudulent intent or conspiracy, it becomes a question of fact, not a medical opinion. A courts-martial board would have to determine this on the basis of evidence and testimony. The psychiatrist should assist this board by his study of the soldier's motives, wishes, frustrations, and other attitudes or feelings, giving a report on his mental condition and responsibilities.

Rarely would the company commander be able to marshal sufficient evidence to prove such a case. On the basis of the medical findings, therefore, an attempt should be made to establish the reasons for such behavior to determine if a remedy is available. It may be that the soldier is the kind of person who was able to get by or to get away with things in civilian life, and tries to bring this way of meeting an unpleasant situation with him into the Army. Such a soldier may benefit from close supervision and discipline, so that he may find out that gold-bricking doesn't pay.

On the basis of the above discussion, the following directions will be carried out:

All instances of presumed malingering (including self-inflicted wounds) will be thoroughly investigated by the appropriate authorities, and, if it is indicated, promptly brought to trial under authority of the 96th Article of War and the appropriate punishment promptly administered.

The services of an experienced psychiatrist, when available, will be utilized for a thorough examination of the suspected individual before charges are made against him. The psychiatrist will submit a written report of his findings to the referring authority. This report will include, in nontechnical terms, the social history, mental status, and the circumstances surrounding the charges; it will state clearly the presence or absence of significant psychiatric disorders and their relation to the act with which the soldier is charged. The psychiatrist will maintain a scientific and not a moralistic role and serve purely in an advisory capacity. If the individual is brought to trial, the psychiatrist may serve as a neutral expert witness for the court.

The attention of all commanding officers is directed to the fact that the reduction of the malingering rate is a responsibility of command. Positive, strong leadership is the best method for reducing non-effectiveness from all psychiatric and psychologic causes. Fear of punishment is, in itself, totally inadequate as a means of preventing malingering.

The attention of all medical officers, particularly psychiatrists, is directed to their responsibility for the detection of malingering and for reporting suspected cases to command.

Prompt action will be taken by commands in the investigation of all suspected cases of malingering. No individual or group of individuals will be needlessly detained for investigation unless there is reasonable supposition of guilt, and charges will not be made unless evidence is reasonably certain. Great care must be exercised to prevent the miscarriage of justice of defamation of character through the filing of erroneous charges of malingering.

It will be mandatory to publish the findings of the court, in each case found guilty of malingering, in such a manner that these findings will be brought to the attention of each soldier within the command involved.

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## PREVENTIVE MEDICINE

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A word should be said about the over-conscientious soldier who pretends to be healthy or tries to avoid sick call or conceals a disability or injury. A soldier's neglected sore throat may quickly result in an epidemic, or even in fatality. An officer would be as aware of the soldier who drives himself too hard, often to the detriment of the company, as of the malingerer who spends his energy avoiding details.

### General

The ratio of psychiatric disorders in World War II to World War I has been three to one. The reason for this is that a great many soldiers are not able to stand alone. They have been over-protected at home and have not been able to break away from their home connections. Too, soldiers in the latter war learned that it was possible to escape undesirable duties or even obtain a discharge by developing neurotic conditions. It must be made known to the soldier that there is a job to be done and he has been selected to do the job. A soldier whose character is such that he won't respond to leadership and his own responsibility to his country should be discharged because of habits and traits undesirable to the service, and not because of neurotic reasons. The psychiatrist can, and will, aid the troubled soldier but strong positive leadership is the best defense for neurotic disorders. A soldier must be made and given the opportunity to keep himself occupied at all times. Good morale is a first aid to many potential mental casualties, just as good first aid improves group morale.

Medical Field Service School, 1949

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## DENTAL SERVICE

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### THOUGHTS ON THINKING J. L. T. Appleton, B.S., D.D.S., Sc.D\*

Like Polonius, all of us read "Words, words, words," and all of us (perhaps too many of us) speak and write "words, words, words." For better or worse, people have ideas, and they often use words to pass these ideas on to others or to remind themselves of these ideas for later use. Precise thinking is indispensable to precise speaking or writing: and the attempt to speak or to write precisely helps our thinking.

As dentists we have ideas to pass on to our patients and to our colleagues: and generally the symbols we use are words. Let us try to use these symbols to make it easy for our patient or colleague to grasp our ideas with the least chance of misunderstanding and with the best chance of moving him to go and do likewise.

As practitioners we are teachers concerned with the interchange of ideas between ourselves and our patients or colleagues. If it is important to save a tooth, it is important to use the best means of saving that tooth; and, if it is important to pass on an idea, it is important to use the best means of passing on that idea.

There are certain obstacles in the way of using the best means: e.g., the temptation to show off, the ambition to appear genteel, the urge to win an argument, and just ignorance of carelessness. In each instance we may be unaware or only half aware of our motives.

"A great deal of what has been called the language of scholarship is the language of pedantry, a great deal of the jargon of specialist is a rather heavy form of intellectual snobbishness".<sup>1</sup> We often see or hear the word caries where the word cavity should be used. Caries is a process, the cavity is the result of that process. A process and its result are distinct ideas: clear thinking is helped by using different words for different ideas. A frequent variant is carious lesion when we mean cavity. However, when I want to designate the earliest discernable change in the enamel (when to speak of a cavity seems far-fetched), carious lesion is justifiable. This illustrates a fundamental rule. Select the word for its specific utility. This is a sound principle of literary economy. If a word serves a useful purpose, save it and use it for that purpose.



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## DENTAL SERVICE

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As another example, let us look at the phrase gingival tissues. What advantage has this combination over the word gum or gums? None, so far as I can see, except to go out of the way to impress my patient. I have no quarrel with gingival third or with gingivitis as there are no other simple symbols on hand for the ideas they respectively represent. With new dentures, my patient may chew his food better. If I have a sense of humor, how can I tell him he will masticate his food better? If you want a patient to know that he may expect trouble from his dentes sapientiae, first show him some wisdom teeth and some x-rays.

Use upper not maxillary, lower not mandibular, milk or baby teeth not deciduous, etc. Now, I get a bit casuistical, and say "use pulp not nerve". Why? Because the pulp is not a nerve and, as there is a difference, that difference should be represented by different words. Besides that, pulp is an easy word. You look at an x-ray (roentgenogram invites trouble in spelling and pronunciation) and remark upon the pathology seen. Now, pathology is the name for the study or science of disease processes and their results: and obviously can't be seen. What is seen in the x-ray is evidence of pathosis -- but this needs translation before it is spoken: what is seen is evidence of some damage done, of some reaction, or of something abnormal or unusual.

Sometimes genteelism and ostentation overlap, and sometimes both motives are at work at the same time. "By genteelism is here to be understood the substituting, for the ordinary natural word ... of a synonym that is thought to be .. less vulgar, less improper..."<sup>2</sup> A mild genteelism is using dentifrice in place of toothpowder. A more serious offense is to use expectorate when one means spit. Anyone who has read Virgil knows the intensity of emotion implicit in imo pectore, "from the depths of his being". A patient with pneumonia or with advanced pulmonary tuberculosis can truly expectorate, raising a pathologic exudate from the depth of his chest. But that is not what we want in the dental chair; we simply want our patients to spit -- a simple, expressive, four-letter Anglo-saxon word. Promiscuous spitting is antisocial and abhorrent as a source of respiratory and wound infection, but spitting into the proper receptacle when told to do so is just what we want our patient to do. In trying to be genteel, we become silly.

The word massage is justifiable. In the first place, it is familiar to everyone and, more important, it represents the idea of a special kind of rubbing, which therefore deserves a special symbol. Similarly, restoration is preferable to filling because restoration aptly describes the goal sought -- a restoration of form, function, and (if possible) appearance.

The abuse of words is a favorite tool of those whose first thought is to win an argument instead of seeking the truth. Fallacies of this origin are well known to formal logic. Some individuals who should know better fall into these fallacies. Here is an illustration. It was when the Chayes movable -- removable system of bridgework was new. A renowned professor, rightly or wrongly, had no use for this system. An undergraduate was honestly trying to find out the reasons for this condemnation. The principle of this system was, I believe, that "teeth move in function". Here is the dialog.

Professor. What is the name of the joint by which the tooth is attached to the jaw-bone?

Student. Synarthrosis.

Professor. What is a synarthrosis?

Student. A joint that permits no motion between the parts articulated.

Professor. Therefore, the tooth cannot move in function, and therefore this system of bridgework rests on a false principle.

Such "reasoning" verges on the immoral. "Begging the question" should be one of the easiest of the fallacies to recognize and to avoid. We lay ourselves open to such fallacies when we take words too seriously and overvalue our reasoning ability. Arguing from definitions smacks of a decadent scholasticism. Our senses notoriously play tricks on us, and our reasoning is even more suspect. Mathematical formulae are magic to most of us, but it takes a Hiroshima to prove that they work. The peculiar strength of the scientific method depends upon its final appeal to nature as the court of last resort.

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## DENTAL SERVICE

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Sometimes just pure thoughtlessness enters here: the thoughtless acceptance of the conventional and the stereotyped. Language frequently serves to hide our ignorance -- and I suppose we are really more honest (or at least, more naive) when we unintentionally allow language to betray (or to suggest) our ignorance. The word caries exists only in the singular. As mentioned above, caries is the name of a process. The patient does not have five caries, he has five cavities.

Every issue of almost every dental journal these days has the word fluorination. I hope this can be corrected before it is too late. The word obviously is based on analogy with chlorination. Now this latter word aptly describes what is done (chlorine is put into the water supply). On the contrary one does not put fluorine into the water supply: one puts in a soluble fluoride (it is the fluoride ion which is effective). Hence, the word fluorination should be used to designate this treatment.

The words saliva and sputum are sometimes used interchangeably. This indicates carelessness in thought and in expression. Teeth are not "irregular" or "crooked" unless malformed: but an irregular arrangement of the teeth may suggest referral to an orthodontist..

There are three words often used synonymously: likely, liable and apt. It would be well to reserve each for a special purpose: likely to indicate probability, liable to indicate responsibility (legal, logical, or moral), and apt to indicate suitability or appropriateness (aptitude).

### CONCLUSION

Choose simple words; the better known, the better. The simple word is usually the short word. "...shortness is a merit in words, ... it is a general truth that the short words are not only handier to use, but more powerful in effect; extra syllables reduce, not increase, vigour".<sup>3</sup> For exposition, scientific or to a laymen, the attempt to keep within the 800-word vocabulary of Basic English is a healthy exercise.

Once you have chosen a word or phrase as the symbol of an idea, stick to that symbol consistently. To do otherwise makes it harder for your listener to keep up with you.

Express your ideas, if possible, in words that are concrete rather than abstract. Your listener or reader will "catch on" more quickly and he's less likely to misunderstand.

Abstracted from "Annals of Dentistry", September, 1949. Vol. 8, No. 3;  
pages 699 to 74

\*School of Dentistry, University of Pennsylvania, Philadelphia, Penna.

<sup>1</sup>Edmans, I. "The Business of the Scholar", Sat. Rev. Lit. New York: 23 July 1949, p. 20

<sup>2</sup>Fowler, H. W. Modern English Usage. London: Oxford Univ. Press, 1926

<sup>3</sup>Ibid

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## ADMINISTRATIVE DIVISION

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### MEDICAL SUPPLY INFORMATION

Item 1-083-505, Ascorbic Acid Tablets, 100's:

Stocks of subject item manufactured by Norwich Pharmacal Company which show evidence of deterioration as shown by formation of brown to black discoloration should be destroyed by Army Stations in accordance with the provisions contained in paragraph 20, SR 735-150-1, dated 1 December 1949.

Item 3-119-760, Bottle, Vacuum, Blood with Anticoagulant, 600 cc, 6's:

Stocks of subject item, which have been examined and found to be unsuitable for use and issue, should be destroyed by Army Stations under the provisions of paragraph 20, SR 735-150-1, dated 1 December 1949.



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## VETERINARY SERVICE

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### ANIMAL DISEASES VERSUS FOOD

by

Major C. W. Tate, V. C.

Veterinarian, Military District of Washington

Since our population is increasing at the rate of nearly two million annually, production of meat, milk, and eggs must likewise be increased if our nation is to continue to be well fed. Veterinarians know that this increase cannot be realized unless the livestock population is reasonably free from disease. Some infectious or contagious diseases do not exist in this country. We are indeed fortunate in having our flocks and herds remain free of rinderpest, surra, foot-and-mouth disease, foulpest, contagious pleurapneumonia and many other destructive maladies. The invasion of foot and mouth disease in Mexico has caused a great deal of alarm among some of our veterinarians and livestock producers. It is a peculiar fact that the occurrence of this and many other highly destructive diseases on other continents and in other countries is accepted as being of little consequence. Man's ingenuity, however, is constantly increasing the danger of invasion of our country by these enemies from the other continents. The airplane measures in hours the distance which separates our flocks and herds from hot beds of these infections and makes every airport in our country a potential point of entry for them. Furthermore, the low temperatures which are so widely employed in preventing spoilage of products of animal origin preserve viruses and bacteria just as effectively as they do meat, milk, and eggs. Experience since the turn of the century has taught us that it takes more than exclusion of infected animals to keep exotic diseases out. In fact, none of the six outbreaks of foot-and-mouth disease of the last fifty years was traced to the introduction of a diseased animal.

Since there is always some danger that one of these diseases may invade our country, in spite of our best efforts at inspection and quarantine, it is the duty of every veterinarian to be constantly alert and to report promptly to state or federal officials the appearance of any unusual or undiagnosed infection.

Many diseases are already established in this country but there has been no widespread epizootics during the past year. Many diseases have held their own and a few have invaded new territory. Those affecting cattle appear to be of the greatest concern and the most important ones will be discussed in succeeding discussions.

Actually in our country we are enjoying the benefits of a reasonably disease-free livestock economy. One has only to open his refrigerator door several times a week for proof. There you see meat, poultry, and all types of dairy products. In a country whose livestock industry has been devastated by disease, the refrigerator picture would be much different, even for the above average type family. For our country to continue to be well fed, we must tighten up and continue to fight all of these diseases with every tool available.

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## MEDICAL SERVICE

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### A TRIP THROUGH THE X-RAY DEPARTMENT OF A GENERAL DISPENSARY

By M/Sgt. Richard Lovell, Registered X-Ray Technician, General Dispensary, USA, The Pentagon

There are quite a few steps to be taken from the time the patient walks into the X-Ray Department until the X-Ray film has been interpreted and the report sent to the doctor. As the patient opens the door of the X-Ray Department he notices the registration office close by where all the paper work and filing is accomplished. He hands to the registration clerk his X-Ray requisition in duplicate and this sets the machinery of the entire Department into motion.

## MEDICAL SERVICE

The clerk inquires firstly as to whether this patient has been X-Rayed in the Department previously, and if so, looks up his old record to obtain the previous registration number. Once a patient has been X-Rayed in this dispensary, he retains the same X-Ray numbers no matter how often he returns nor how long the interval is between X-Ray examinations. This information, together with the patient's full name, serial number, rank, and part to be examined are all carefully transcribed on the Daily Work Sheet. This ledger is the key to all activities of the X-Ray Service. The number assigned to the patient is prepared in small lead numbers, placed on a strip of adhesive tape which has previously been prepared with the date and the name of the dispensary in order to save time in completion of this step. The patient is then assigned to one of the radiographic rooms, there being three in all, and he is requested to have a seat in the waiting room to await his turn. In the meantime, his requisition, to which is attached the X-Ray number and other data on the adhesive strip using lead letters, is taken back to the radiographic room to which the patient has been assigned.

In an emergency case, however, the patient is taken immediately to the radiographic room and the waiting period is eliminated. In such cases, all "red tape" is eliminated and possibly no longer than twenty minutes elapses between the time the patient arrives in the Department and when his films are viewed wet.

The routine case to be X-Rayed is called in his turn to the proper X-Ray room and the X-Ray technician takes over the next steps of the procedure. He studies the old films, if any, to determine what portion of the body has been X-Rayed in the past, and also scrutinizes the X-Ray requisition which is supposed to indicate all the details of the part to be X-Rayed plus the suspected diagnosis in the appropriate place. The technician and his assistant then place the patient on the X-Ray table and the part to be studied is aligned to the X-Ray tube and to the X-Ray film. A careful measurement of the part that is being radiographed is noted so that an accurate technique may be set up for the individual patient. When this is accomplished, the various controls on the X-Ray machine are manipulated and the X-Ray exposure is made. The X-Ray technician then dismisses the patient and places the exposed film, or films, into the pass box which leads into the radiographic dark room.

In this section of the Department there is one dark room technician. His job is not to be envied for he works in dim red illumination possibly from early morning until duty hours are over. The dark room technician takes the film just made, removes it from the holder known as a cassette, and attaches it to a developing frame. He then processes the film through the developer, fixer, and wash water at prescribed intervals of time. The film is finally placed into a dryer and when the drying process is completed, the corners are cut and the film is returned to the clerk's office. The clerks sort out the film and are able to identify the film belonging to the individual patient by the lead number which has been reproduced in clear markings on the X-Ray film. The negative presser, or envelope, which is to retain the film, is attached to the films ready for interpretation, plus the original X-Ray requisition. These films are then turned over to the radiologist for the final step, namely, the interpretation of the X-Ray findings.

The radiologist studies the film and makes out a report of his findings which is transcribed on the original request by the stenographer. His reports are re-read after coming from the stenographer and initialed and are finally sent to the medical officer who referred the patient to the X-Ray Department, and then become a part of the patient's chart.

The old adage that a chain is no stronger than its weakest link applies so well to a Radiographic Department. If an error creeps in, either in registration of the patient, or in technique, or in the dark room processing of the X-Ray film, the radiologist may not be able to offer an accurate interpretation. In this Department, therefore, the greatest care is exercised in order that few mistakes will be made.

You will notice that all precautions have been taken for the protection of personnel and patients, such as lead lining of the room and the control booth behind which the technician stands, and careful calibration of all equipment so that patients and operators will not receive a dangerous amount of X-Ray. It is for these reasons that all personnel using this expensive X-Ray equipment must be thoroughly and completely trained to utilize X-Rays to their best advantage and to obviate any harmful consequences.



## GENERAL COMMENT

The health of the command continued to be satisfactory.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and II installations exclusive of Walter Reed General Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army medical installations do include those Air Force personnel who are treated or hospitalized at the reporting unit on a casual basis, since reciprocal use of other service's medical installations is made. Air Force statistics are tabulated separately for units having Air Force personnel assigned. (See General Data and Admissions Tables on page 12).

The non-effective rate rose slightly over the February rate of 14.48 to 15.56 for the month of March, 1950. Days lost as a result of disease and injury totalled 9349 during the five-week period ending 31 March 1950.

The total admissions for disease and injuries in March was 1,224. Of this number, 1,158 admissions were for diseases and 66 for injuries. The 1,224 admissions for all causes (diseases and injuries) during the report period was a decided increase from the 882 cases of the previous month. The rate for March is 743.7; February's rate was 664.0. "All Others" reported the lowest rate with 438.7 and Fort Myer reported the highest with 1,914.8.

March's rate for disease cases is 703.6 for 1,158 cases. The lowest rate for the admission of disease was reported by Fort McNair, with a rate of 341.3 and Fort Myer reporting the highest with a rate of 1,825.2.

The incidence of injuries for the month of March was 40.1 for 66 cases. The General Dispensary, USA, The Pentagon, reported the lowest rate with 18.3 for 6 cases; and Fort McNair reported the highest rate for the report period, 105.9 for 9 cases.

No deaths were reported during the 5-week period ending 31 March 1950.

## COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of March, 1950 with 332 cases reported with a rate of 201.7. February's rate was 125.7 for 167 cases. Fort Belvoir reported the highest incidence of respiratory diseases with a rate of 231.9. The lowest incidence was reported by Fort McNair, with a rate of 58.8.

Admission rates for pneumonia during March was 12.8, for 21 cases, which may be compared with February's rate of 14.3.

No cases of measles, scarlet fever or malaria were reported throughout March, 1950.

Pertinent statistical tables may be found on pages 12 and 14.

## GOOD NEIGHBOR POLICY

In evaluating the health of a command, equal consideration must be given to the civilian community adjacent to the military station, the civilian population living within the station and to the military personnel. Almost always the health experiences of the military command parallel those of the civilian community. Frequently, the local military preventive medicine officer can anticipate health trends within his command by following closely the health experiences within the nearby civilian communities. In order to do this, a close liaison with municipal and state health agencies is necessary. We have long recognized that the civilian community has constituted the reservoir of venereal infection for the soldier. It is equally true that the civilian community is a reservoir for other infectious diseases. The answer to the question: "How are we going to empty this civilian reservoir of disease," depends on how firmly the liaison between military preventive medicine and civilian public health practices has been established. The command surgeon, the post medical inspector, and the post sanitary inspector can do much toward establishing this liaison by working with his opposite number in the civilian agency.

Abstracted from Second Army Health Bulletin for March, 1950.

**RESTRICTED****PREVENTIVE MEDICINE**

GENERAL DATA  
5-week Period Ending 31 March 1950  
(Data from Wd AGO Forms 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective-Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir (A)	8140	6870	1270	528	676.4	507	649.5	21	26.9	13.33	0
(AF)	152	148	4	21	1440.7	21	1440.7	0	-	17.48	0
Fort McNair (A)	886	808	78	38	447.3	29	341.3	9	105.9	18.38	0
(AF)	94	94	0	0	-	0	-	0	-	-	0
Fort Myer (A)	1514	1323	191	278	1914.8	265	1825.2	13	89.5	31.72	0
(AF)	0	0	0	2	-	2	-	0	-	-	0
South Post, Fort Myer (A)	1633	1633	0	127	811.0	124	791.8	3	19.2	18.28	0
(AF)	0	0	0	0	-	0	-	0	-	-	0
General Dispensary, (A)	3421	3387	34	187	570.0	181	551.7	6	18.3	16.19	0
USA (AF)	3368	3349	19	139	430.4	135	418.0	4	12.4	13.08	0
All Others (A)	1569	1569	0	66	438.7	52	345.6	14	93.0	5.79	0
(AF)	65	65	0	1	160.4	1	160.4	0	-	1.32	0
Total Mil Dist of Wash (A)	17163	15590	1573	1224	743.7	1158	703.6	66	40.1	15.56	0
(AF)	3679	3656	23	163	462.0	159	450.7	4	11.3	12.72	0
AMC - Med Det (Duty Pers) *	1573	1447	126	129	855.2	127	841.9	2	13.3	9.64	1
AMC - Med Hold Det*	1212	1089	123	118	1015.3	109	937.8	9	77.4	988.12	2
AMC - Total (Army)	2785	2536	249	247	924.9	236	883.7	11	41.2	435.47	3
AMC - Total (Air Force)	588	561	27	49	869.0	41	727.1	8	141.9	700.83	1
AMC - Total (A & AF)	3373	3097	276	296	915.1	277	856.4	19	58.7	481.72	4
Total - Dept/Army Units	19948	18126	1822	1471	769.0	1394	728.7	77	40.3	74.19	3
Total-Dept/Air Force Units	4267	4217	50	212	518.1	200	488.8	12	29.3	107.54	1
*Army personnel only.											

\*Army personnel only.

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR  
5-week Period ending 31 March 1950  
(Data from WD AGO Forms 8-122)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diar-rheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir (A)	231.9	24.3	15.4	-	-	17.9	-	1.3	2.6	-	5.1	-	6.4
(AF)	411.6	-	-	-	-	-	-	-	-	-	-	-	-
Fort McNair (A)	58.8	-	-	-	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (A)	206.6	13.8	13.8	1391.3	-	13.8	-	-	-	-	6.9	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
South Post, Fort Myer (A)	223.5	-	-	236.3	-	6.4	-	-	-	6.4	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
General Dispensary, (A)	182.9	-	-	237.8	-	6.1	-	-	-	3.0	-	-	9.3
USA (AF)	170.3	3.1	3.1	151.7	-	6.2	-	-	-	-	-	-	3.1
All Others (A)	139.6	-	-	-	-	6.6	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Mil Dist of Wash (A)	201.7	12.8	8.5	192.6	-	12.2	-	0.6	1.2	1.2	3.0	-	4.8
(AF)	172.9	2.8	2.8	138.9	-	5.7	-	-	-	-	-	-	2.8
*AMC- Med Det (Duty Pers)	106.1	-	-	291.7	-	6.6	-	-	-	6.6	-	-	-
*AMC- Med Hold Det	103.2	25.8	25.8	25.8	-	-	-	-	-	-	-	-	17.2
AMC - Total (Army)	104.8	11.2	11.2	176.0	-	3.7	-	-	-	3.7	-	-	7.5
AMC - Total Air Force	70.9	-	-	141.9	-	17.7	-	-	-	-	-	-	-
AMC - Total (A & AF)	98.9	9.3	9.3	170.0	-	6.2	-	-	-	3.1	-	-	6.2
Total Dept/Army Units	188.2	12.5	8.9	190.3	-	11.0	-	0.5	1.0	1.6	2.6	-	5.0
Total Dept/Air Force Units	158.9	2.4	2.4	139.3	-	7.3	-	-	-	-	-	-	2.4

\*Army personnel only.

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# PREVENTIVE MEDICINE

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## VENEREAL DISEASE

Venereal disease rate among units within the Military District of Washington has continued a downward trend during the report period.

The rate for March 1950 was 12.15, a decrease over the February rate of 16.56. A rate of 23.54 was reported by Fort McNair.

A total of 20 cases were reported for the 5 week period ending 31 March 1950. Of this total 18 were reported by Fort Belvoir.

During the report period, white personnel incurred 12 of the reported number of cases, with a rate of 8.03 and 8 were incurred by Negro personnel, with a resulting rate of 53.03 per 1000 troops per annum.

Four of the said number of cases were reported as syphilis, and 16 as gonorrhea.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (March) in addition to the rate per 1000 men per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 14, 15, 16, and 17.

### NEW VENEREAL DISEASE CASES - EXCL EPTS - JANUARY, FEBRUARY, AND MARCH 1950

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	JANUARY 50	FEBRUARY 50	MARCH 50	MARCH 50
Fort Belvoir	42.42	21.93	23.06	2.21
Fort McNair	14.29	14.90	23.54	2.26
Fort Myer	-	-	-	-
South Post, Fort Myer	7.80	8.12	-	-
General Dispensary, USA	3.75	-	-	-
All Others	7.91	49.63	-	-
Total Mil Dist Wash Units	23.35	16.56	12.15	1.17
Army Medical Center - Total	10.26	9.96	7.49	0.72
Total Dept/Army Units, Mil Dist of Washington	21.72	15.65	11.50	1.10

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# PREVENTIVE MEDICINE

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY  
MDW RATE PER 1000 TROOPS PER YEAR

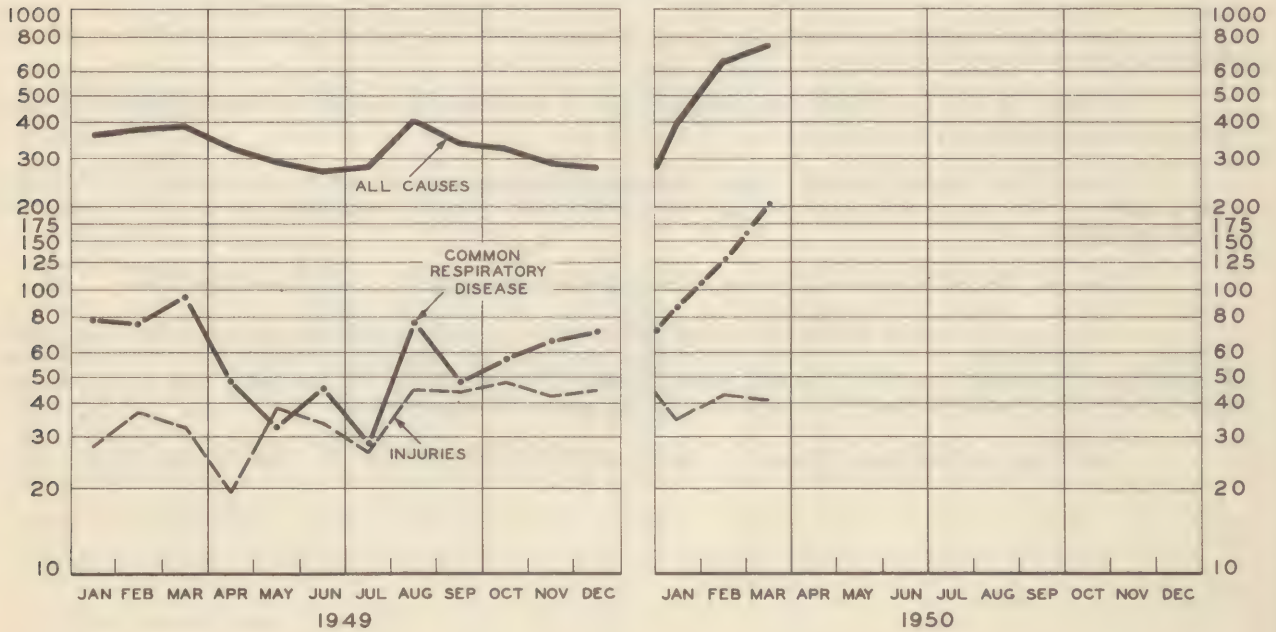
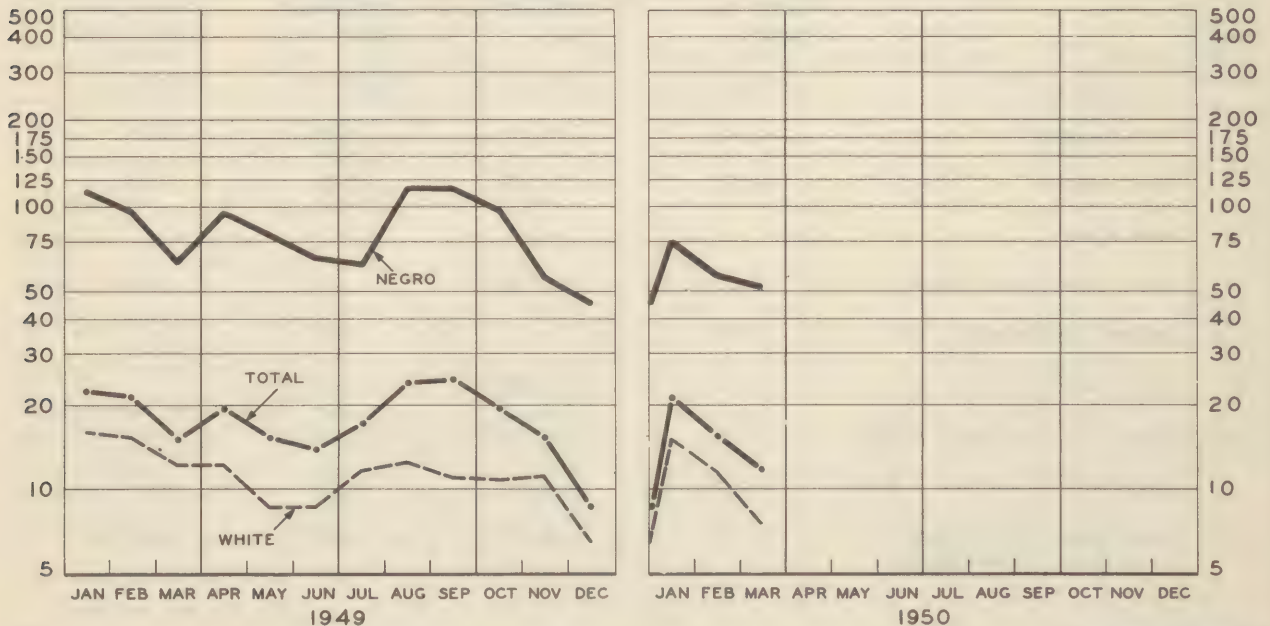


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW INCL. ARMY MEDICAL CENTER  
RATES PER 1000 TROOPS PER YEAR  
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



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# PREVENTIVE MEDICINE

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## CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT For the Five Week period ending 31 March 1950 (Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	6870	3	8	0	11	16.70	8
	N	1270	1	6	0	7	57.48	0
	T	8140	4	14	0	18	23.06	8
Fort McNair	W	808	0	1	0	1	12.91	0
	N	78	0	1	0	1	133.69	0
	T	886	0	2	0	2	23.54	0
Fort Myer	W	1323	0	0	0	0	-	0
	N	191	0	0	0	0	-	0
	T	1514	0	0	0	0	-	0
South Post, Fort Myer	W	1633	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	1633	0	0	0	0	-	0
General Dispensary, USA	W	3387	0	0	0	0	-	0
	N	34	0	0	0	0	-	0
	T	3421	0	0	0	0	-	0
All Others	W	1569	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	1569	0	0	0	0	-	0
Total Mil Dist of Wash	W	15590	3	9	0	12	8.03	8
	N	1573	1	7	0	8	53.03	0
	T	17163	4	16	0	20	12.15	8
Army Medical Center -Total	W	2536	0	0	1	1	4.11	206
	N	249	1	0	0	1	41.88	133
	T	2785	1	0	1	2	7.49	339
Total Dept/Army Units	W	18126	3	9	1	13	7.48	214
	N	1822	2	7	0	9	51.51	133
	T	19948	5	16	1	22	11.50	347

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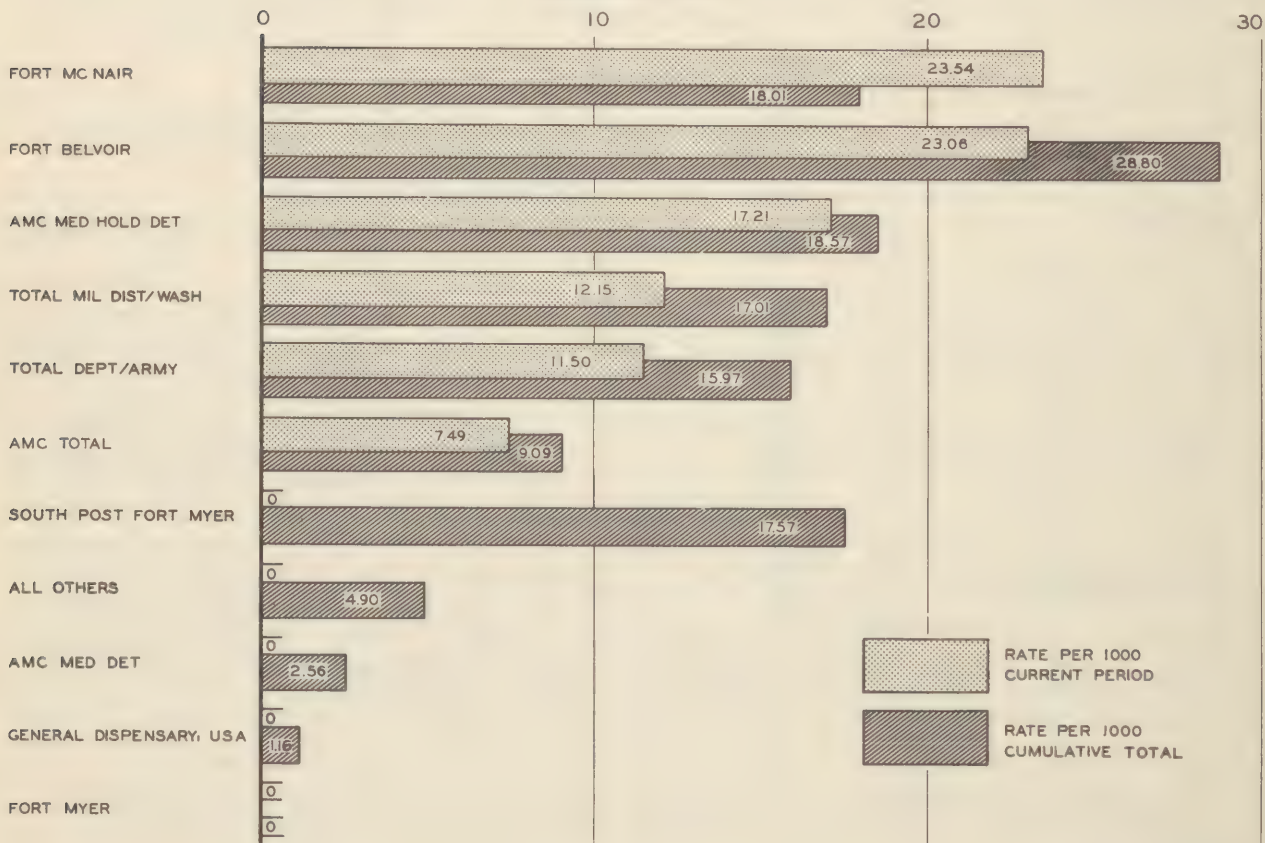
## VENEREAL DISEASE RATES FOR US\*

(All Army Troops)

	JANUARY 1950	FEBRUARY 1950	MARCH 1950
First Army Area	12	11	17
Second Army Area	19	21	16
Mil District of Washington	20	12	11
Third Army Area	26	22	24
Fourth Army Area	21	16	13
Fifth Army Area	16	15	19
Sixth Army Area	20	21	20
TOTAL United States	20	18	18

\*Compiled in the Office of the Surgeon General and Includes General Hospitals

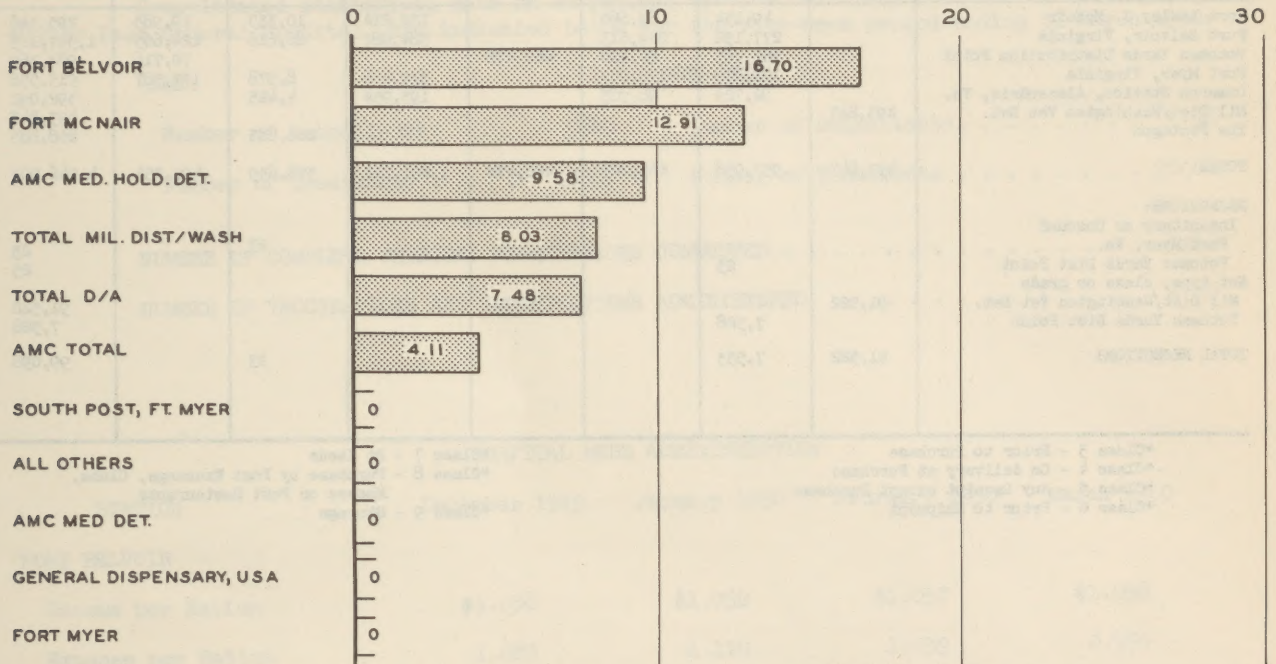
**VENEREAL DISEASE  
RATES PER 1000 PER YEAR  
FIVE WEEK & CUMULATIVE TOTALS ENDING 31 MARCH 1950  
TOTAL WHITE & NEGRO PERSONNEL  
(CHARGEABLE CASES)**

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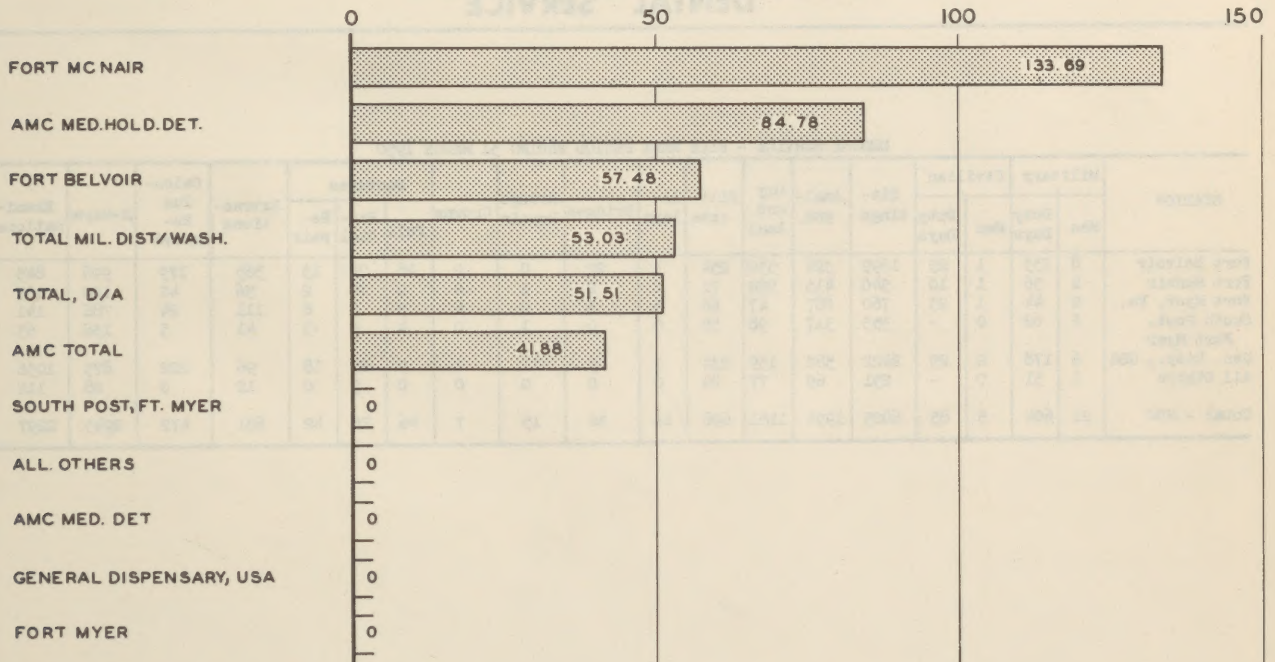
## VENERAL DISEASE RATE PER 1000 TROOPS PER YEAR

5 WEEK PERIOD ENDING 31 MARCH 1950  
WHITE PERSONNEL (CHARGEABLE CASES)



## VENERAL DISEASE RATE PER 1000 TROOPS PER YEAR

5 WEEK PERIOD ENDING 31 MARCH 1950  
NEGRO PERSONNEL (CHARGEABLE CASES)



**RESTRICTED****VETERINARY SERVICE**

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED MARCH 1950  
(Data obtained from WD AGO Forms 8-134)

	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		49,154	83,660		132,214	10,335	19,983	295,346
Fort Belvoir, Virginia		277,132	244,613		584,087	86,616	224,665	1,397,113
Potomac Yards Distribution Point		365,765	84,410	462,478			70,716	983,369
Fort Myer, Virginia		172,278	178,057		379,456	8,378	177,387	915,556
Cameron Station, Alexandria, Va.		92,729	98,983		195,954	4,425		392,091
Mil Dist/Washington Vet Det.	493,847							493,847
The Pentagon						268,885		268,885
TOTAL	493,847	957,058	669,723	462,478	1,291,711	378,639	492,751	4,746,207
REJECTIONS:								
Insanitary or Unsound								
Fort Myer, Va.						23		23
Potomac Yards Dist Point		25						25
Not type, class or grade								
Mil Dist/Washington Vet Det.	91,522							91,522
Potomac Yards Dist Point		7,528						7,528
TOTAL REJECTIONS	91,522	7,553				23		99,098

\*Class 3 - Prior to Purchase  
\*Class 4 - On delivery at Purchase  
\*Class 5 - Any Receipt except Purchase  
\*Class 6 - Prior to Shipment

\*Class 7 - At Issue  
\*Class 8 - Purchase by Post Exchange, Clubs,  
Messes or Post Restaurants  
\*Class 9 - Storage

**DENTAL SERVICE**

DENTAL SERVICE - FIVE WEEK PERIOD ENDING 31 MARCH 1950

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Calcu- lus Re- moved	X-Rays	Exami- nations
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	8	233	1	23	1699	324	530	254	3	22	0	2	28	20	13	365	179	996	843
Fort McNair	2	56	1	10	540	415	290	71	2	2	1	0	0	10	2	56	42	120	102
Fort Myer, Va.	2	44	1	23	760	287	47	60	5	3	2	4	5	5	6	111	24	788	141
South Post, Fort Myer	2	62	0	-	353	317	98	55	0	0	1	0	4	9	-3	41	5	138	63
Gen. Disp., USA	6	178	2	29	2422	582	139	234	1	5	11	1	9	27	18	96	222	875	1036
All Others	1	31	0	-	251	69	77	24	0	0	0	0	0	5	0	12	0	28	112
Total - MDW	21	604	5	85	6025	1994	1181	698	11	32	15	7	46	76	42	681	472	2945	2297

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## ADMINISTRATIVE DIVISION

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### OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed General Hospital, are indicated below for the five-week period ending 31 March 1950:

#### ARMY:

Number of Outpatients. . . . . 5649

Number of Treatments . . . . . 18867

#### NON-ARMY:

Number of Outpatients. . . . . 5706

Number of Treatments . . . . . 20084

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED . . . . . 1214

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED. . . . . 4636

### HOSPITAL MESS ADMINISTRATION

STATION	December 1949	January 1950	February 1950	March 1950
FORT BELVOIR				
Income per Ration	\$1.038	\$1.052	\$1.057	\$1.058
Expense per Ration	1.083	1.119	1.039	0.980
Gain or Loss	-0.045	-0.067	+ 0.078	+ 0.018

## ADMINISTRATIVE DIVISION

The following list of publications is of particular interest to the Medical Department:

### DEPARTMENT OF THE ARMY SPECIAL REGULATIONS

SR No.	Subject	Date
600-400-10 C-1	Personnel -- Casualty Reporting for Missing Personnel	7 Mar 50
40-225-21	Medical Service -- Yellow Fever Immunization Requirements -- Pakistan	10 Mar 50

### DEPARTMENT OF THE ARMY MEMORANDA

Memo No.	Subject	Date
40-505-2 C-1	Medical Service in the Military District of Washington	1 Mar 50

### DEPARTMENT OF THE ARMY CIRCULARS

Cir. No.	Subject	Date
13	Rodenticide, Sodium Monofluoracetide	1 Mar 50
13	U.S.M.A. Graduates Class of 1947	1 Mar 50
15	Communication with Veterans Administration	15 Mar 50

### MILITARY DISTRICT OF WASHINGTON MEMORANDA

Memo No.	Subject	Date
11	Directory and Station List of the Military District of Washington	2 Mar 50
12	Use of Medical Services in the Military District of Washington	3 Mar 50
14	Operating Procedure for Military District of Washington	9 Mar 50
	Ordnance Maintenance Inspection Teams	
15	Post Activities re Armed Forces Day	20 Mar 50
16	Wearing of Summer Uniform	24 Mar 50
17	Appointment List of Personnel to the Military District of Washington Control and Evacuation Staff	30 Mar 50

### MILITARY DISTRICT OF WASHINGTON CIRCULARS

Cir. No.	Subject	Date
9	Section I -- Foreign Service	10 Mar 50
	Section II -- Re-enlistment of Personnel Discharged Under Provisions of SR 615-365-5	10 Mar 50
10	Promotions of Enlisted Personnel	17 Mar 50
11	Examining and Computing Agencies	20 Mar 50

### PUBLICATIONS ORIGINATED IN OFFICE OF SURGEON, MDW

ANWMC File No.	Subject	Date
440	Re-Distribution of Excess Medical Supplies	3 Mar 50
701	Medical Treatment	6 Mar 50
201.5	Final Type Physical Examination	8 Mar 50
705	Admission to Hospital	Undated
352	Training Conducted at Civilian Institutions for Regular Army Nurses	15 Mar 50
701	Appearance Before Physical Evaluation Boards	15 Mar 50

